Chapter Eight

Reimbursement and Billing

Chapter Overview

Introduction

This chapter is designed to help the hospital provider understand reimbursement policies, especially third party payers, hospital payment methods, specific policies that dictate how payments are determined, and specific instructions for completing and submitting UB-92 claim forms.

In This Chapter

This chapter contains:

Third Party Payers

Third Party Recovery (TPR)

The objectives of the Department of Medical Assistance Third Party Recovery Section are to:

- identify and recover money from third parties liable to the recipient for medical expenses and damages
- identify and recover money from recipients who have received payment from third parties liable for medical expenses
- cost avoid Medicaid dollars when a primary payer is identified

The TPR Section operates under Federal laws (42 U.S.C.§1396a(a)(25) and 42 C.F.R.§§433.135, *etseq.*) and the following North Carolina State statutes:

- Casualty, Tort and other Liability scenarios: N.C.G.S.§108A-57. This section addresses Medicaid's subrogation rights
- First Party Benefits: N.C.G.S.§108A-59. This section addresses Medicaid's assignment rights.

Third Party Liability Guidelines

Federal regulations require Medicaid to be the "payer of last resort." This means that all third parties including Medicare, CHAMPUS, Workers Compensation liability carriers, and private health insurance carriers must pay before Medicaid may pay. Additionally, providers must report any such payments from third parties on claims filed for Medicaid payment.

Medicaid-Allowed Amount

If the Medicaid-allowed amount is more than the third party payment, Medicaid will pay the difference up to the Medicaid-allowed amount. If the insurance payment is more than the Medicaid-allowed amount, Medicaid will not pay an additional amount.

Exceptions

Certain Medicaid programs are not considered "primary payers" regarding the payer of last resort provision. When a Medicaid recipient is entitled to one or more of the following programs or services, Medicaid pays first:

- Vocational Rehabilitation Services
- Division of Health Services of the Blind
- Division of Health Services "Purchase of Care" Programs:
  - Cancer Program
  - Prenatal Program
  - Sickle Cell Program
  - Crippled Children's Program
  - Kidney Program
  - School Health Fund
  - Tuberculosis Program
  - Maternal and Child Health Delivery Funds

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Third Party Payers, Continued

Medicaid Dual Eligibles	Medicaid pays Part A premiums for all Medicaid recipients who are not entitled to "free" Part A. Medicaid also pays for Part B premiums for all Medicaid recipients. *No Part A or Part A Benefits Exhausted:* When the hospital files inpatient ancillary charges under Part B where no Part A coverage exists, Medicare automatically crosses over that claim to Medicaid for the deductible and co-insurance amounts. Because no Part A coverage exists, the provider may file a straight claim to Medicaid for the hospital inpatient charges, which are paid on a DRG. When the provider crosses over the ancillary charges to Part B and files a straight claim for the inpatient charges to Medicaid, Medicaid makes a duplicate payment because the ancillary charges billed under Part B are already included in Medicaid's inpatient DRG payment. The provider must refund Medicaid the co-insurance/deductible amount it paid on the crossover, and file the straight claim to Medicaid with the Medicare Part B payment indicated on the claim. *All other Part B charges except Hospital inpatient ancillaries:* File only the Medicare claim to Part B as a crossover and DO NOT FILE A STRAIGHT CLAIM to Medicaid indicating the Medicare payment. Medicaid will pay the co-insurance on the Part B crossover and this is the only amount Medicaid owes. Filing a straight claim to Medicaid indicating the amount of Medicare payment results in a duplicate payment by Medicaid.

Noncompliance Denials

Effective December 1, 1997, state and federal third party liability laws mandate Medicaid not pay for services denied by private health plans due to noncompliance with those plan requirements. If the provider's service would have been covered and payable by the private plan, but some requirement of the plan was not met, Medicaid will not pay the service.

If the recipient has a private plan and does not inform the provider of such plan, and if the plan's requirements were not met because the provider was unaware of them, the provider may bill the recipient for those services, if both the private plan and Medicaid deny payment due to noncompliance.

Similarly, if the recipient fails to cooperate in any way in meeting any private plan requirement, the provider may bill the recipient for the service(s). If, however, the recipient does present the private payer information to the provider and that provider knows that he or she is not a participating provider in the plan or cannot meet any other of the private plan requirements, the provider must inform the recipient of such and also tell the recipient that he or she will be responsible for payment of services.

Common noncompliance denials include failure to get a referral from a primary care physician, failure to go to a participating provider, failure to acquire a second opinion, failure to acquire pre-approval, etc.

Discounted Fee-For-Service Payments

The Medicaid program makes payment to providers on behalf of recipients for medical services rendered but Medicaid is not an "insurer". Medicaid is not responsible for any amount for which the recipient is not responsible. Therefore, a provider cannot bill Medicaid for any amount greater than what the provider agreed to accept from the recipient's private plan. If the recipient is not responsible for payment, then Medicaid is not responsible for payment. The provider should bill only the amount that the provider has agreed to accept as payment in full from the private plan.

Continued on next page

Third Party Payers, Continued

Capitated Payments

When a provider accepts a capitated payment from a private plan and bills Medicaid for any balance, the provider must bill **ONLY** the **COPAYMENT AMOUNT** due from the recipient. **DO NOT BILL MEDICAID THE FULL CHARGES**, even with the capitated amount indicated as an insurance payment. Medicaid is not responsible for any amount in excess of that amount for which the recipient is responsible.

How To Know If Third Party Liability Exists

The following suggestions help determine if a Medicaid recipient has third party liability:

1. The recipient's Medicaid Identification (MID) card lists in the Insurance Data block up to three health and/or accident (not auto or life) insurance policies and Medicare Part A and/or Part B applicable to the recipient(s). Insurance information on the card will include:
   - insurance company name (by code)
   - insurance policy number
   - insurance type (by code)
2. When services are rendered, providers should ask the recipient if he or she has any additional health insurance coverage or other third party liability. If health insurance is indicated, the provider bills the carrier before billing Medicaid. Before filing a claim with Medicaid, the insurance company must pay the claim or issue a written denial to the provider.
3. When a claim is submitted to and denied by Medicaid, the provider remittance advice will indicate the other insurance company (by code), the policyholder name, and the certificate or policy number.

An "Insurance Company Code Book" can be obtained from Third Party Recovery at DMA upon request. The code book has a 2-digit "key" for the types of insurance coverage listed on the MID card.

What to Do If The Insurance Company Does Not Provide Written Denial

If a provider is unable to get a written denial from an insurance company or other third party payer, that provider can attach a completed DMA-2057, Health Insurance Information Referral form (see Attachment B) to the claim, indicating the name and telephone number of the individual verifying the third party denial. Also attach a DMA-2057 when:

- insurance coverage has lapsed
- the recipient has an insurance policy not listed on the MID card
- to change incorrect information on the MID card

Send the DMA-2057 attached to the claim copy to Third Party Recovery at DMA.

Time-limit Overrides on Third Party Liability

All Medicaid claims must be received by EDS within 365 days from the date of service, other than inpatient hospitals, home health or nursing facility services (within 365 days from date of service on hospital inpatient claims); or within 180 days from a third party denial or partial payment in order to be accepted for processing and payment. Faxed claim copies are not accepted. Override of the time limit will be granted if the claim is filed within 180 days of the third party denial, provided the claim was filed with the third party within the 365-day time period and within 18 months of date of last remittance advice.

All requests for time-limit overrides due to the third party not responding within the Medicaid time limit must be addressed to the Third Party Recovery Section at DMA. Include documentation of timely filing with the request.

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Third Party Payers, Continued

Refunds to Medicaid

When a provider does not learn of other health insurance coverage for a recipient until after receipt of Medicaid payment, the provider must:
file a claim with the health insurance company, and
upon receipt of payment, refund Medicaid the insurance payment or the Medicaid payment in full, whichever is less, and
the provider may keep the larger payment

Submit refunds on the Medicaid Refund Form (available from EDS) and fill it out completely for correct handling and identification of the refund. Provider refunds are sent to EDS, unless DMA requests in writing that it be sent to another address.

One of the functions of the Third Party Recovery Section is to ensure that Medicaid is the payer of last resort. When a recipient is identified as having other insurance coverage and the provider has been paid by Medicaid, Third Party Recovery forwards a letter to the provider of service. The provider will be asked to file insurance for the dates of service listed and to refund the insurance payment or the Medicaid payment, whichever is less, to the Post Payment area of the Third Party Recovery Section.

If the provider did not receive payment from the insurance carrier because the claim was rejected or denied, then the provider must send a copy of the EOB in the response to TPR. If there is no response in 60 days from the date of the letter, Third Party Recovery will request EDS to recoup this money for the specific date of service from the providers' next checkwrite.

Tort (Personal Injury) Liability

Medicaid recipients may qualify for other third party reimbursements because of an accident, illness, or disability. A third party, other than those already cited, may be legally liable. Frequently these injuries and illnesses result from automobile accidents or on-the-job injuries or illnesses not covered by Workers' Compensation.

North Carolina General Statute §108A-57 allows the State subrogation rights, i.e., the State has the right to recover any Medicaid payments from personal injury settlement awards.

Provider Rights In Personal Injury Cases

When a provider learns that a Medicaid recipient has been involved in an accident, the provider **must** notify the Third Party Recovery (TPR) section. If the provider has knowledge of the accident at the time of filing the claim, a Recovery Accident Information report (DMA-2043) must be submitted with the claim. A DMA-2043 must also be submitted when anyone requests a copy of the bill. See Attachment C.

The following information is required by TPR to pursue a case, and would assist the provider when filing a claim with the liability carrier:

- name of insurance company
- name of insured person responsible
- insurance policy number
- name and address of the attorney, if any

Note: A copy of a letter sent by an attorney or insurance carrier to the provider requesting information will suffice in lieu of the DMA-2043.

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Third Party Payers, Continued

Deciding Who To Bill	The provider must choose between billing Medicaid and billing the liability carrier. A casualty claim **cannot** initially be filed with Medicaid, receive payment, and then bill the liability carrier (or the recipient) for the same service, even if the provider refunds Medicaid. The provider cannot bill the recipient, Medicaid or the liability carrier for the difference between the amount Medicaid paid and the provider's full charges. See Evanston Hospital V. Hauck, 1 F.3d 540 (7th Cir. 1993)

Billing Medicaid	If the provider withholds billing Medicaid, the provider has 6 months from the date of an insurance or attorney letter denying or making payment to file with Medicaid, even where it is in excess of the 365 day filing deadline. The following requirements must be met: • provider must file a claim with the third party carrier or attorney within 365 days from the date of service • provider makes a bona fide and timely effort to recover reimbursement from the third party • the provider submits documentation of partial payment or denial with a claim to Medicaid within 6 months of such payment or denial When Medicaid payment is received the provider is paid in full and there is no outstanding balance on that claim. Once Medicaid makes a payment for a service, it alone has the right to seek reimbursement for payment of service. If the provider withholds billing Medicaid and receives a liability payment, the provider may bill Medicaid with the liability payment indicated on the claim. Medicaid may pay the difference if the Medicaid allowable amount is greater than the liability payment.

Receiving Payment From a Liability Carrier

Providers may receive liability payments when the providers have not pursued or sought third party reimbursement. The provider may not keep any liability payment in excess of Medicaid's payment. Pursuant to Federal regulations and the Evanston case, there is a distinction between private health insurance payments and other liable third party payments. If Medicaid discovers that a provider received Medicaid payment and communicates with a third party payer or attorney in an attempt to receive payment of any balance, Medicaid will recoup its payment to that provider immediately, regardless of whether the provider ultimately receives payment from that third party.

The following is an example of how a liability payment should be treated:

Amount billed by provider to Medicaid	$100.00
Amount paid by Medicaid	$50.00
Amount paid by Attorney/Liability carrier	$100.00
Amount to be refunded to Medicaid	$50.00
Amount to be refunded to Attorney/Liability	$50.00

Billing the Medicaid Recipient	Whether a provider can bill the recipient at any time depends upon how the provider accepted the recipient as a patient. The provider must make the decision initially to accept the patient as a Medicaid patient before rendering the service. This decision is irreversible.

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Third Party Payers, Continued

Accepting the Recipient as a Medicaid Patient	When the provider accepts a recipient's Medicaid card initially upon the rendering of the service(s), the provider accepts the recipient as a Medicaid patient, thereby accepting Medicaid's payment as payment in full. If the provider accepts the recipient as a Medicaid patient, the provider may never bill the patient for that service. This is true even where the provider withholds billing Medicaid to seek full reimbursement from a liability carrier. If the provider withholds billing Medicaid and fails to receive sufficient reimbursement from the third party carrier, the provider's only option is to file a claim with Medicaid indicating the liability payment, if any, on the claim. If the recipient refuses to cooperate with the provider in seeking reimbursement from the third party carrier (by assisting or providing information where necessary), the provider may bill the recipient for the full charges until recipient complies with needed information (42 CFR §433.147).

Refusing the Recipient as a Medicaid Patient	The provider may refuse to accept the recipient's Medicaid card initially upon the rendering of the service(s). The provider **must** make it clear to the recipient that the provider is accepting them as a private pay patient only and that the recipient will be personally responsible for payment of the services. When accepting the recipient as a private pay patient the provider may bill the recipient for the full charges. If the provider does not receive sufficient reimbursement from a liability carrier, the provider may bill the recipient for the balance. The provider may use whatever legal means available to collect the debt. This includes receiving a pro-rata share of the one-third available per statute for the reimbursement of medical expenses and attempting to recover any remaining balance from the recipient's one-third recovery amount, not to exceed 50% of the net settlement amount exclusive of attorney fees.

Requesting a Copy of the Bill	When the recipient or other authorized agent requests a copy of the bill, the words "MEDICAID RECIPIENT, BENEFITS ASSIGNED" must appear in large, bold print on all copies of all bills which were or will be submitted to Medicaid. If a provider fails to comply with this requirement, Medicaid may recoup the amount it paid for each claim which failed to comply regardless of whether the provider receives payment or not from the third party. If the provider chooses not to submit a bill to Medicaid initially the provider must put the words "MEDICAID RECIPIENT" on the bill because: 1. the provider may decide to file with Medicaid after giving out a copy of the bill 2. this language will inform attorneys and insurance companies that Medicaid may be involved

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Attachment A

Third Party Liability—Commonly Asked Questions

1. **Q:** Why did my claim deny for EOB 094 "Refile indicating insurance payment or attach denial?"

A: EDS/DMA's database indicates the recipient had third party insurance on the date of service for which you are requesting reimbursement. Our records show this type of insurance should cover the diagnosis submitted for payment. If your service could be covered by the type of insurance indicated, you **must** file a claim with that insurance company prior to billing the Medicaid Program. If you receive a denial or payment for less than your charges, bill the Medicaid Program and, if appropriate, your claim will be processed and paid. It is the provider's responsibility to secure any additional information needed from the Medicaid recipient to file the claim.

If the insurance data was not indicated on the MID card, it was entered on the database after the MID card was printed and should be on the next MID card. You may also find this insurance information on your denial RA. **Note:** This denial does not refer to Medicare.

2. **Q:** How do I determine the name of the third party insurance company that is indicated on the recipient's MID card?

A: An Insurance Code Book is available upon request from the DMA Third Party Recovery Section. This code book is a key to the code that is listed on the MID card in the insurance data block under the subheading "Name Code." See Appendix B for address and fax number.

3. **Q:** How do I determine what type of insurance the recipient has?

A: The blue and pink MID cards list an insurance name code, policy number, and type of insurance code. The buff MID card lists the insurance name code only. The insurance type codes are listed below. This is a key to be used by the providers in identifying third party resources as shown by the code on the MID card in the insurance data block under the subheading "Type."

The codes listed below are DMA codes and have no relationship with the insurance industry.

Code	Description	Code	Description
00	Major Medical Coverage	09	Medicaid HMO Contract
01	Basic Hospital w/Surgical Coverage	10	Major Medical & Dental Coverage
02	Basic Hospital Coverage Only	11	Major Medical & Nursing Home Coverage
03	Dental Coverage Only	12	Intensive Care Coverage Only
04	Cancer Coverage Only	13	Hospital Outpatient Coverage Only
05	Accident Coverage Only	14	Physician Coverage Only
06	Indemnity Coverage Only	15	Heart Attack Coverage Only
07	Nursing Home Coverage Only	16	Prescription Drugs Coverage Only
08	Basic Medicare Supplement	17	Vision Care Coverage Only

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Attachment A (Page 2)

Third Party Liability—Commonly Asked Questions, Continued

4. **Q:** What is considered an acceptable denial from an insurance company?

A: An acceptable denial is a letter or EOB from the insurance company or group/employers on company letterhead. Only denials that do not indicate noncompliance by the provider or recipient with the private plan will be acceptable denials for Medicaid payment. If a denial is questionable, such as a returned claim with "applied to deductible" written in, the claim should be forwarded to the DMA Third Party Recovery Section. See Appendix B for address.

If the provider has an acceptable denial or EOB, attach the denial to the claim and forward to EDS Occurrence codes may be used on the UB-92 for this information. Documentation must be kept on file for a minimum of 5 years at the provider's office. See Appendix B for address.

5. **Q:** What are the uses of the DMA-2057 form (Health Insurance Information Referral Form) and where do I obtain copies?

A: The DMA-2057 form should be completed in the following instances:

- when a written denial is unattainable;
- to delete insurance information, (i.e., a recipient no longer has third party insurance, but the MID card indicates other insurance);
- to add insurance information, (i.e., a recipient has third party insurance that is not indicated on the MID card) (include termination of insurance date);
- to change existing information, (i.e. a recipient has Major Medical third party coverage that is type coded as vision coverage only on the MID card.) (include effective date of policy)

DMA-2057 forms can be ordered from your service relations analyst by calling 1-800-688-6696.

6 **Q:** How should I file my Medicare Part B crossover claim when a recipient is covered by a third party insurance company?

A: If a telephone denial is received from the third party company, a copy of the DMA-2057 form should be completed and attached to the claim and Medicare voucher. These should be sent to the Division of Medical Assistance, Third Party Recovery Section. See Appendix B for address.

If a written denial is received from the third party company, a copy of this denial (including the explanation of denial code), claim copy and Medicare voucher should be sent to EDS Provider Services. See Appendix B for address.

If you have any questions, please call the Division of Medical Assistance, Third Party Recovery Section, Cost Avoidance Unit. See Appendix B for telephone number.

Attachment B

Division of Medical Assistance

Health Insurance Information Referral Form

Recipient Name:_____

Recipient ID No:_____Date of Birth:_____

Health Ins. Co. Name (1) _____Policy/Cert No._____

(2)_____Policy/Cert No._____

Reason For Referral

1._____ Patient not covered by above policy(s)

2._____ Service not covered by above policy(s)

3._____ Insurance company denied by_____letter or_____telephone (please provide name and number of contact person and reason for denial):

_____

_____

4. New policy not indicated on Medicaid ID card. Indicate type coverage:

_____	Major Medical	_____	Hosp/Surgical	_____	Basic Hospital
_____	Dental	_____	Cancer	_____	Accident
_____	Indemnity	_____	Nursing Home		

5. Insurance company paid patient $_____ Date_____and patient has not paid provider.

If items 1 through 3 are checked, attached original claim and submit to: The Division of Medical Assistance, Third Party Recovery Section, 2508 Mail Service Center, Raleigh, North Carolina 27699-2508. The Third Party Recovery (TPR) Section will verify the information and will either override or reject the claims within 10 working days after receipt and forward claim to EDS for processing.

Item 4 should be used if the patient requests filing with an insurance company that is not indicated on the Medicaid ID card. The TPR Section will enter this information into the TPR database.

Submitted:_____ Provider Number:_____

By:_____ Date Submitted:_____

Telephone Number:_____

DMA-2057

Attachment C

_____County DSS County Case No:_____
_____County Number

Third Party Recovery "Accident" Information Report

Casehead:_____
Last First Middle Initial

Name of Injured Recipient: _____
Last First Middle Initial

Recipient's Individual Medicaid ID No:_____

Location of Accident: _____
City County
Street/Road Name or Number: _____

Date of Accident: _____

Type of Accident: _____(Auto, Home, Work-Related, etc.)

Name of Insured Person Responsible for Accident:_____

Name of Insurance Company or Insurance Agent: _____

Policy No: _____ Accident Claim No:_____

Name of Recipient's Attorney, If Any: _____

Comments:_____
_____
_____

Submitted By: _____ Title:_____
Date:_____ Telephone No: _____

Mail Original To: North Carolina Department of Health and Human Services
Division of Medical Assistance
Third Party Recovery Section
2508 Mail Service Center
Raleigh, NC 27699-2508
(919) 733-6294

DMA-2043 (Rev 4/90)
PS-00246

Health Insurance Premium Payment Program (HIPP)

What is HIPP?

The Health Insurance Premium Payment Program (HIPP) pays health insurance premiums for Medicaid recipients when it is cost-effective. Cost-effectiveness is proven when the annual cost of premium, deductible, and coinsurance is less than the anticipated Medicaid expenditures.

Who Qualifies?

HIPP is most cost-effective for Medicaid recipients with catastrophic illnesses such as end-stage renal disease, chronic heart problems, congenital birth defects, cancer, or AIDS. For any such recipient who would lose private health insurance coverage due to nonpayment of premiums, Medicaid will determine the cost-effectiveness of paying private health insurance premiums. To be eligible for Medicaid payment of premiums:

- the recipient must be Medicaid-authorized and have access to private health insurance
- DMA will only pay the premiums on existing policies or those known to be available to the recipient. DMA will not find new health insurance coverage for recipient
- premiums will be paid on a family coverage policy when the policy is cost-effective and is the only way the recipient can be covered
- family members who are not Medicaid-eligible will not receive Medicaid payment for deductible, coinsurance, or cost-sharing obligations

Requirements

When DMA determines that a group health insurance plan available to the recipient through an employer is cost-effective, the following conditions apply:

1. the recipient is required to participate in the plan as a condition of Medicaid eligibility
2. if the recipient voluntarily drops the insurance coverage or fails to provide the information necessary to determine cost-effectiveness, Medicaid eligibility will be terminated
    a) recipient is not required to enroll in a plan that is not a group health insurance plan through an employer; **however**
    b) if the policy is determined to be cost-effective, DMA will pay the cost of premium, coinsurance, and deductible for nongroup health plans, if the recipient chooses to participate

Referral

If the provider has reason to believe the recipient meets any of the conditions cited, contact DMA's HIPP Coordinator (See Appendix B) for review.

Medicaid Credit Balance Report

Medicaid Credit Balance Reporting

Hospitals are required to submit a Quarterly Medicaid Credit Balance Report (Attachment D) reporting all outstanding Medicaid credit balances reflected in the hospital's accounting records as of the last day of each calendar year.

The report is used to monitor and recover "credit balances" due to Medicaid. A credit balance is defined as an improper or excess payment made to a provider as the result of recipient billing or claims processing errors. For example, if a provider is paid twice for the same services (e.g., by Medicaid and another insurer), a refund must be made to Medicaid.

What to Report

A Medicaid credit balance is an amount determined to be refundable to Medicaid. Generally, when a provider receives an improper or excess payment for a claim, it is reflected in accounting records (patient accounts receivable) as a "credit." Medicaid credit balances, however, include money due the program regardless of its classification in a provider's accounting records.

For example, if a provider maintains a credit balance account for a stipulated period, e.g., 90 days, and then transfers the account or writes it off to a holding account, this does not relieve the provider of its liability to the program. In these instances, the provider is responsible for identifying and repaying all of the monies due Medicaid.

When To Send the Report

Send the report to DMA no later than 30 days following the end of the calendar quarter (March 31, June 30, September 30, and December 31). **A report is required even if a zero ($0.00) credit balance exists.**

Failure to submit a Medicaid Credit Balance Report in a timely manner could result in the withholding of Medicaid payments until the report is received.

Completing the Report Form

The detail form requires specific information on each credit balance on a claim-by-claim basis. The detail form provides space for 12 claims, but it may be reproduced as many times as necessary to report all the required credit balances. Specific instructions for completing the report are on the reverse side of the report form.

Where To Send the Report

Submit **only** the completed Medicaid Credit Balance Report to Third Party Recovery at the address listed in Appendix B.

Send any refunds due or recoupment requests to EDS with all the necessary documentation to process the refund or recoupment. **Do not** send refunds or recoupment requests to DMA.

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Attachment D

MEDICAID CREDIT BALANCE REPORT

PROVIDER NAME: _____ CONTACT PERSON: _____

PROVIDER NUMBER: _____ TELEPHONE NUMBER: (_____) _____

QUARTER ENDING: (Circle one) 3/31 6/30 9/30 12/31 YEAR:_____

(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
RECIPIENT'S NAME	MEDICAID NUMBER	FROM DATE OF SERVICE	TO DATE OF SERVICE	DATE MEDICAID PAID	MEDICAID ICN	AMOUNT OF CREDIT BALANCE	REASON FOR CREDIT BALANCE
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							
11.							
12.							

(See instructions on next page)

Circle one: Refund Adjustment

Instructions for Completing Medicaid Credit Balance Report

Complete the Medicaid Credit Balance Report as follows:

- Full name of facility as it appears on the Medicaid Records
- The facility's Medicaid provider number. If the facility has more than one provider number, use a separate sheet for each number, DO NOT MIX.
- Circle the date of quarter end
- Enter year
- The name and telephone number of the person completing the report. This is needed in the event DMA has any questions regarding some item in the report

Complete the data fields for each Medicaid credit balance by providing the following information:

Column 1 - The last name and first name of the Medicaid recipient (e.g., Doe, Jane)

Column 2 - The individual Medicaid identification (MID) number

Column 3 - The month, day, and year of beginning service (e.g., 12/05/99)

Column 4 - The month, day, and year of ending service (e.g., 12/10/99)

Column 5 - The R/A date of Medicaid payment (not your posting date)

Column 6 - The Medicaid ICN (claim) number

Column 7 - The amount of the credit balance (not the amount your facility billed or the amount Medicaid paid)

Column 8 - The reason for the credit balance by entering: "81" if it is a result of a Medicare payment; "83" if it is the result of a health insurance payment; "84" if it is the result of a casualty insurance/attorney payment or "00" if it is for another reason. Please explain "00" credit balances on the back of the form.

After this report is completed, total column 7 and mail to DMA.

Hospital Reimbursement Methods

Overview

Three separate pricing methods are used to reimburse institutions:

1. Diagnosis Related Grouping
2. Per Diem
3. Ratio of Cost to Charge

10 NCAC 26H.0210 provides details of hospital rate setting. DMA gives annual written notification of individual rates to providers. Providers may appeal their rates within 60 days of receiving a rate change.

Post Payment Review

Medical records supporting billings to North Carolina Medicaid are subject to monthly review by state and federal auditors or their agents to assure proper payment. The reviews verify:

- accuracy of coding on the claim compared to medical records
- medical necessity
- conformity with Medicaid policy
- appropriate payment for Medicaid services

Diagnosis Related Grouping

General acute care hospitals, excluding inpatient psychiatric and rehabilitation services, are reimbursed at a Diagnosis Related Grouping (DRG) payment method. Payment is based on patient diagnoses, surgical procedures and other criteria. Each DRG is assigned a specific "weight," which is used in determining the DRG payment. Once the DRG is assigned and a weight has been determined, this weight is multiplied by the hospital's specific rate to calculate the DRG-allowable. A rate letter containing the hospital specific rates and inpatient ratio of cost to charge is sent annually to each hospital's Chief Financial Officer.

The DRG-maximum-allowable is calculated by adding the DRG-allowable to any applicable outlier payments. Payment is increased for disproportionate share hospitals (DSH) when applicable.

DRG-maximum-allowable = DRG-allowable + Outlier payment + DSH

Charges for noncovered services and services not reimbursed under the inpatient DRG methodology (such as professional fees) are deducted from total billed charges. Noncovered charges include revenue codes that are Medicaid noncovered (denied with EOB 009) and revenue codes invalid for inpatient claims, e.g. revenue codes 550, 559, 560, 570, 580 and 590. The remaining billed charges are converted to cost using a hospital-specific cost-to-charge ratio. The cost-to-charge ratio excludes medical education costs. The cost and day outliers are calculated as follows: *Cost outlier = DRG outlier percentage of 75% x*

[(RCC x covered charges) - outlier cost threshold]

Day outlier = DRG outlier percentage x (covered days - day threshold) x

(DRG amount /Average Length of Stay)

If the claim qualifies for both cost and day outlier payments, both will be calculated, and the greater of the two payments will be applied to the DRG allowable.

Prorated DRG

When patients must be transferred from one acute care facility to another, both the transferring facility and the receiving facility will be paid. The transferring facility is entitled to a prorated DRG amount. If the required days of the acute care stay are greater than or equal to the average length of stay assigned for the DRG, the transferring facility is eligible for the entire amount. If the required days of the acute care stay do not exceed the average length of stay assigned for the DRG, the prorated payment is calculated this way: *DRG prorated payment = [(DRG payment x Actual Length of Stay) / DRG Average Length of Stay]*

The receiving facility will receive the usual DRG payment unless the patient is transferred again. **Note:** Patient status (Block 22) must reflect "02" patient transfer.

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Hospital Reimbursement Methods, Continued

Ratio of Cost to Charge

Outpatient services and Indian Health Hospitals are reimbursed as Ratio of Cost to Charge (RCC). The RCC is calculated by comparing year-end cost of operation to the year-end charges paid Medicaid. DMA assigns an RCC yearly to each facility. Covered hospital outpatient services (with the exception of lab services) are paid at 80% of the hospital's RCC.

Out-of-state providers are no longer reimbursed for inpatient services by the RCC method. Generally, out-of-state providers are reimbursed in the same manner as in-state providers.

Per Diem

The following are reimbursed by per diem:

- inpatient psychiatric and rehabilitation services
- skilled nursing facility/intermediate care facility care in acute care facilities
- swing-bed hospital units
- state-operated hospitals
- inpatient psychiatric or substance abuse DRGs 424-437
- inpatient rehabilitation DRG 462

Split Eligibility

Claims paid by the DRG Reimbursement System are calculated for the entire length of stay, even if the recipient is only eligible for a portion of days within that stay. The recipient cannot be billed for the noncovered days of eligibility because payment is calculated as if the recipient were covered for the entire stay. Report noncovered but paid days on the cost report.

Claims paid at the per diem rates (including psychiatric and rehabilitation services) are paid for the number of Medicaid covered days.

Psychiatric and rehabilitation claims are submitted under DRG guidelines. Claims processing will split the noneligible segments and payment is made for covered days only. The recipient may be billed for the noncovered days.

Cost Outliers

A cost outlier payment is an additional payment made when a claim for exceptionally costly services is processed. These payments are subject to retrospective review by DMA. Cost outlier payments may be reduced if and to the extent that the preponderance of evidence on review supports a determination that the associated cost either exceeded the cost of medically necessary care, or was for services not covered by NC Medicaid.

A cost outlier threshold is established for each DRG at the time DRG relative weights are calculated using the same information used to establish those relative weights. The cost threshold is the greater of $25,000 or the geometric mean cost for the DRG plus 1.96 standard deviations.

If the cost for the claim exceeds the cost outlier threshold, a cost outlier payment is made at 75% of the cost above the threshold.

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Hospital Reimbursement Methods, Continued

Day Outliers

A day outlier payment is an additional payment made for an exceptionally long length of stay for children under age six (6) at disproportionate share hospitals and children under age one (1) at hospitals that are not disproportionate share facilities. These payments are subject to retrospective review by DMA. Day outlier payments may be reduced if and to the extent that the preponderance of evidence on review supports a determination that the associated cost either exceeded the cost of medically necessary care or was for services that were not covered by NC Medicaid.

A day threshold is established for each DRG at the time DRG relative weights are calculated, using the same information. The day outlier is the greater of 30 days or the arithmetic average length of stay for the DRG plus 1.50 standard deviations.

A day outlier payment may be made for covered days in excess of the day outlier threshold at 75% of the hospital's payment rate for the DRG rate divided by the DRG average length of stay.

Outlier Payments

Cost and day outlier thresholds are established for each DRG at the time DRG relative weights are calculated.
Outlier payments may be reduced if:

- the associated cost either exceeded the cost or
- services were not medically necessary or
- services were not covered by the North Carolina Medical Assistance program

Out-of-State Providers

Out-of-state providers are reimbursed by the same methods as in-state providers.

Other Reimbursement Policies

Inpatient Services With Part B Coverage Only

When a Medicaid recipient who has received inpatient hospital services has Part B Medicare coverage only, or has Part B and the Part A benefits have been exhausted:

1. A claim for Part B charges must be filed with the Medicare carrier first.
   a) Do not indicate on the claim filed to Medicare that these charges should be crossed over to the Medicaid program.
2. Follow these instructions for proper billing sequence:
   a) File charges covered under Medicare Part B to Medicare.
   b) Receive payment from Medicare.
   c) File the UB-92 to Medicaid completing the routine required fields.
   d) Complete the following:
      - Form locator 4 – indicate the proper bill type
      - Form locator 32-35 a-b, code A3-C3 – indicate that the patient has no Medicare Part A or these benefits are exhausted. Lifetime reserve days must also be exhausted
      - Form locator 50 – indicate Medicare as payer
      - Form locator 54 – indicate the Medicare Part B payment. Do not include the contractual adjustment
   e) Do not attach a copy of the Medicare EMOB
3. The payment from Medicare for the Part B charges is treated like any other third party payment since the original charges are included in the Medicaid per diem/DRG rate.

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Other Reimbursement Policies, Continued

Procedure for Reimbursement of Medicaid Monies for Medicare/ Medicaid Dually Eligible	When Medicare should have been the primary payer of services Medicaid paid providers for: • TPR recoups the entire Medicaid payment by sending an adjustment form to EDS and notifies the provider that an adjustment has been sent • The letter itemized the recipient name and MID number, the referenced dates of service, the Medicare HIC number, the Medicare entitlement date, medical record numbers, if applicable, and the total amount of the adjustment • The letter advised the provider to file with Medicare and <u>not to send a refund check to Medicaid upon receipt of the letter</u> File the claim with Medicare, and if the Medicare number is cross-referenced to the NC Medicaid provider number, the Medicare claim for coinsurance and/or deductible will automatically cross over to Medicaid. Providers who file with Medicare must indicate Medicaid on the claim in order for the crossover to take place.

Illegal Aliens

Eligibility for emergency care of illegal aliens is determined once the stay is complete. Once eligibility is established for any period of the hospital stay, and upon submission of a claim, the base DRG or DRG-allowable is calculated. The provider receives 50% of this DRG-allowable and no outliers are included in the payment. The recipient may be billed for the remainder of the DRG-allowable.

If the DRG is for a delivery, the reimbursement is 100% of the DRG-allowable. No outlier payments are made in this situation. The hospital cannot bill the illegal alien recipient when Medicaid has paid for a delivery.

Disproportionate share supplements are not paid on claims for illegal alien recipients.

Deductible Balance for Inpatient Claims	The recipient's deductible balance on the eligibility file is automatically applied by the system during processing of inpatient hospital claims. When a recipient's eligibility begins during an inpatient stay, the hospital should receive a DMA-5020 from the county DSS giving the amount of the deductible balance. The deductible balance on the eligibility file is the same amount the county DSS reports on the DMA-5020. If this form has not been received, ask the county DSS for a completed DMA-5020. Refer to Chapter Three, *Overview of the North Carolina Medicaid Program*, "Medicaid Eligibility" for further information concerning Medicaid Deductible. An adjustment may be requested if the amount of the deductible balance applied in processing is different than the amount on the DMA-5020. Attach a copy of the DMA-5020 to the adjustment request and send to EDS. See Appendix B for address.

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Other Reimbursement Policies, Continued

Recipient Liability for Inpatient Claims

When an individual receives long-term care, Federal regulations require any monthly income or resources be applied to institutional care costs before Medicaid payments are made. The county DSS determines how much per month the recipient can contribute from his resources toward this long-term care.

- a Medicaid recipient admitted from a private living arrangement to a hospital is subject to patient liability for inpatient charges beginning the first day of the month following the thirtieth (30) day beyond the date of admission.
- a recipient admitted from an intermediate care, intermediate care/mental retardation, or skilled nursing facility is considered as a continuing long-term care patient and is subject to patient liability immediately upon admission.
- liability information is provided to the hospital through the State eligibility system. A DMA-5016 (PA-25) form is generated from county input keyed into the State eligibility file to the facility where the patient is a resident. The hospital must notify the recipient's county DSS that the recipient's length of stay has exceeded 30 days, or that a long-term care recipient has been admitted.
- the hospital retains the DMA-5016 (PA-25) in their files, but bills claim with the money amount in Form Locator 39 with a value code of 23. Failure to indicate either the money amount or -0- will result in denied claims or recoupment of liability amount.
- the county DSS staff issue a manual form DMA-5016 when the liability is split between facilities and hospitals due to patient transfer.
- the amount of patient monthly liability on the eligibility file is automatically applied to long term care claims.
- additional DMA-5016s will be issued only when the recipient's monthly liability changes.

Automatic Deduction

The patient liability amount on the eligibility file is automatically applied when

- the "from" date of service is the first day of the month
- claims are received for processing in contiguous date of service order

The patient liability amount must be entered on the claims when

- patient was not in the facility on the first day of the month
- patient was admitted from long term care
- hospitalization spans more than one month and interim bills are submitted

In Form Locator 39 on claim form UB-92, enter value code 23 and amount of patient liability.

Teleconsulting Billing

The consulting practitioner at the HUB site (the medical center or facility from which the consultant performs the consult) receives 75% of the fee schedule amount for the consult code. The referring practitioner at the SPOKE site (the facility in which the patient exam is performed) receives 25% of the applicable fee.

Services provided by the practitioners employed by the hospital participating in the SPOKE site teleconsult are billed on the UB-92 claim form by the hospital. Only the SPOKE portion of a teleconsult can be billed on the UB-92.

- RC 780 and the CPT code is entered onto the UB-92 claim form
- E & M codes are entered in field locator 44 on the UB-92
- Modifiers are not required on the UB-92 when billing services

Neonatology Claims

Neonatology Claims

Special consideration is given to claims for neonates. Certain DRGs are replaced with a North Carolina unique neonatal DRG. These neonatal DRGs are included in the yearly rates sent to hospitals by DMA. A set of special North Carolina Medicaid DRGs is defined in Table 1. Table 2 includes DRGs that can be replaced by the unique North Carolina Medicaid DRGs in Table 1.

DRG	TABLE 1 Description	Weight	Cost Outlier Threshold	Day Outlier Threshold	DRG Average LOS
801	Neonates BW < 1000 grams	15.9046	105,401	133	73.1
802	Neonates BW 1000-1499 grams	5.9371	51,494	73	37.8
803	Neonates BW 1500-1999 grams	1.8423	25,000	33	15.0
804	Neonates BW >= 2000 grams with RDS	2.7907	35,311	46	15.9
805	Neonates BW >= 2000 grams premature with major problems	1.1053	25,000	30	8.5
810	Neonate low birth weight DX over 28 days old at admission	3.8681	58,807	77	26.0

DRG	TABLE 2 Description	Weight	Cost Outlier Threshold	Day Outlier Threshold	DRG Average LOS
385	Neonates, died or transferred to another acute care facility	0.3680	25,000	30	0.8
389	BW >/= 2,000 grams full term neonate with major problems	0.6628	25,000	30	4.6
390	BW >/= 2,000 grams full term with problems or premature without major problems	0.2767	25,000	30	2.5
391	BW >/= 2,000 grams full term without complicating diagnosis	0.2175	25,000	30	1.9

Criteria For Unique Neonatal DRGs

The following criteria specify when DRGs 385, 389-391 are replaced with a North Carolina unique neonatal DRG. These criteria can be used for programming specifications:

- only DRGs 385, 389 through 391 can be replaced
- if the age at admission was greater than 28 days, assign DRG 810
- if the DRG is 385 and the length of stay was less than or equal to three days, keep DRG 385
- if the DRG is 385 and the length of stay was three days or more, move Patient Status 01 (discharged to home) to the discharge status and use the HCFA Grouper to regroup the claim; after the claim has been regrouped then the birth weight must be determined
- the birth weight will be identified by the fifth digit of the diagnosis code for diagnosis codes 76400 through 76519
- if the birth weight is < 1000 grams, assign DRG 801
- if the birth weight is >/= 1000 and < 1500 grams, assign DRG 802
- if the birth weight is >/= 1500 and < 2000 grams, assign DRG 803
- If the diagnosis code 769 (Respiratory Distress Syndrome) is found on the claim and the birth weight is >/= 2000 grams, assign DRG 804
- if the DRG is 390 and the birth weight is >/= 2000 grams, assign DRG 390
- if the DRG is 389 or 391 and the birth weight is >/= 2000 grams, keep the DRG assignment

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Neonatology Claims, Continued

Billing Extra Corporeal Shock Wave Lithotripsy Services

For hospitals that own and operate a lithotripter, ESWL services must be billed on a UB-92 claim using revenue code 79X. If the patient is admitted on the same day that the ESWL services were rendered, the services must be filed as an inpatient claim and will be reimbursed based on the hospital's DRG rate. The charges billed for revenue code 79X should include the hospital's ESWL operating cost only. Other ancillary services should be billed according to their revenue codes. Physician services must be billed separately on a HCFA 1500 claim.

If a hospital owns a mobile lithotripter and provides services at the site of another hospital, a claim for the ESWL services can be filed only by the owning hospital. The claim must be filed on a UB-92 claim form.

If ESWL services are rendered by a mobile lithotripter owned by a provider other than a hospital, the services must be billed on a HCFA 1500 claim form using code 50590 for the professional component and code 50591 for the machine usage. Hospitals that have contracts with mobile lithotripsy providers cannot file UB-92 outpatient claims for ESWL services. As with other professional services, hospitals can submit the HCFA 1500 claim on behalf of the lithotripsy providers. Payment will be in accordance with the fixed fees established for ESWL services.

Inpatient Claims

Claims Payment

In accordance with 10 NCAC 26H.0210 and the State Medicaid Plan, inpatient hospital services for general acute care hospitals are reimbursed by DRG as previously discussed on page 8-14. Generally, claims submission guidelines parallel those for inpatient Medicare claims submission. The DRG reimbursement system does not alter the UB-92 claim form requirements or prevent claims from being submitted electronically. Omission of required UB-92 fields may cause denial of payment. Contact EDS for questions. See Appendix B

Services Ruled Not Necessary

When Medicaid is the primary payor and an entire hospital stay or any portion of an inpatient hospital stay is denied, the charges for that denied stay (or any portion of that stay) will not be covered by Medicaid.

Payment for Medical, Remedial Care, and Observation Services: Inpatient Hospital

In order to be eligible for inpatient hospital reimbursement under this hospital reimbursement plan, a patient must be admitted as an inpatient and stay past midnight in an inpatient bed. The only exceptions to this requirement are those admitted inpatients who die or are transferred to another acute care hospital on the day of admission.

Services for patients admitted and discharged on the same day and who are discharged to home or to a non-acute care facility must be billed as outpatient services. Patients who are admitted to observation status do not qualify as inpatients, even when they stay past midnight. Patients in observation status for more than 30 hours must either be discharged or converted to inpatient status. Claims reporting outpatient observation in excess of 30 hours may be recouped upon postpayment review.

Day of Admission

The day of admission is the day a person is admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services and counts as one patient day. If admission and death occur on the same day, the day is considered a day of admission and counts as one inpatient day.

Continued on next page

Inpatient Claims, Continued

Leave of Absence

Scheduling conflicts may require a recipient to return home for a short period after being admitted as an inpatient. The recipient should not be discharged and readmitted upon his or her return, and the claim should be billed as a continuous stay. A leave of absence revenue code 180 should be billed for each day the recipient was away from the facility. The claim reflects charges for the entire stay. The Admit Date should equal the From Date of Service and is billed through the discharge date. Leave of absence days will be included in this span of dates.

Discharge Day

The day of discharge is not counted as a day of patient care.

Late Discharge

When a recipient continues to occupy his accommodations beyond the checkout time for personal reasons, Medicaid will not make payment for the continued stay. However, it is expected that institutions will not impose late charges on a recipient, unless he has been given reasonable notice (for example, 24 hours) of his impending discharge.

Hospital Readmission Within 72 Hours

If a recipient is readmitted within 72 hours of being discharged as a hospital inpatient, and the readmission is for the same or related conditions as the original admission, the claim will be reviewed by DMA for medical necessity and quality of care. When indicated, recoupments will be made.

Inpatient Crossovers

Payment Method

Inpatient crossovers (excluding SNF crossovers) will be paid using the DRG assigned by Medicare. The Medicaid DRG-allowable is calculated, and the Medicare total payment is deducted from it. The remainder is compared to the Medicare coinsurance and deductible amount. Payment is made for the lesser of the two amounts.

If a facility's Medicare DRG payment is higher than its Medicaid payment, no crossover payment is made. The facility cannot bill the patient for the coinsurance/deductible. This payment (or nonpayment) must be accepted as payment in full. These deductible and coinsurance amounts can be claimed on the Medicare cost report as bad debts. Refer to the Medicare HCFA Health Insurance Manual 15-2, section 312, or if applicable, Section 310.

Medicare/ Medicaid Crossover	Medicare claims cross over automatically to Medicaid **if** the provider's Medicare number is cross-referenced to their North Carolina Medicaid provider number in Medicaid's cross-reference files. If providers have Medicare claims that are not automatically crossing over to Medicaid, a Medicare Crossover Reference Request form may be completed and sent to EDS Provider Enrollment (See Attachment E). Contact EDS Provider Enrollment for more information. See Appendix B for telephone numbers.

Acute Care Hospitals

When Medicare benefits begin or exhaust during an acute hospital stay, Medicaid, effective with date of service January 1, 1995, does not pay for noncovered Medicare days. The hospital's reimbursement is a DRG payment from Medicare based on the assigned DRG, not number of covered days. Medicaid liability is limited to the coinsurance/deductible as explained in the previous Payment Method block.

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Inpatient Crossovers, Continued

Inpatient Psychiatric and Rehabilitation Split Eligibility

Inpatient psychiatric and rehabilitation Medicare/Medicaid crossovers with split eligibility segments are paid as follows:

1. Compare the FROM and TO dates of service on the claim to the Medicaid eligibility.
2. The total number of Medicaid-eligible days is multiplied by the Medicaid per diem rate.
3. The Medicare payment is subtracted from this total.
4. The result is compared to the sum of the coinsurance and deductible amounts.
5. The lesser of these two amounts is paid.

Inpatient Psychiatric and Rehabilitation Stays When Medicare Benefits Begin or Exhaust

When Medicare benefits begin or exhaust in the middle of an inpatient psychiatric or rehabilitation stay, the crossover claim will be processed as follows:

1. If the Medicare voucher indicates covered and noncovered days, the crossover claim is split into two details.
   a) Detail one includes the Medicare-covered days multiplied by the Medicaid per diem rate less the Medicare payment. This sum is compared to the coinsurance/deductible. The lesser amount is the total of detail one.
   b) Detail two will be the Medicare-noncovered days multiplied by the Medicaid per diem rate.
2. The total payment will be the sum of detail one and detail two.

Note: The RA will show only the result of these calculations and will not show the actual totals for details one and two.

Inpatient Psychiatric and Rehabilitation Claims

Payment

Psychiatric and rehabilitation hospital Medicaid claims are always paid a per diem. General hospitals are also reimbursed a per diem for psychiatric and rehabilitation services grouped to psychiatric and rehabilitation DRGs.

- inpatient psychiatric and rehabilitation claims are submitted like all other inpatient claims
- all diagnoses and procedure codes should be accurately represented on every claim. These claims will process through the system and be assigned to a specific DRG
- claims grouped to DRG 424-437 will signal the system to pay at the facility's psychiatric per diem
- claims grouped to DRG 462 will signal the system to pay at the facility's rehabilitation per diem rate
- per diem payments will always be made using the rate effective on the To Date of Service

Guidelines

When submitting inpatient psychiatric and rehabilitation claims, the following guidelines apply:

- the only valid Bill Types for these claims are 111, 112 or 117
- the Admit Date should always match the From Date of Service
- all information submitted on the claim should be an accumulation of total charges, all third party and patient liabilities, and all appropriate diagnoses and procedures for the entire stay
- out of state psychiatric claims require a prior approval number from First Mental Health

Lower Level of Care

Lower Level of Care and Swing-Bed Rates

The rates for hospital lower level of care and swing-bed rates per patient day are subject to annual change. These rates are published every November in the Medicaid Bulletin.

Effective with date of service October 1, 1998, the hospital lower level of care and swing bed rates per patient day are: Skilled Nursing Care—$111.94
Intermediate Care—$84.92
Ventilator-Dependent Care—$343.91

Submit claims for lower-level portions of the stay following per diem payment guidelines.

Lower Level of Care

When a patient no longer meets acute care requirements and is approved for a skilled nursing facility or intermediate care facility, the hospital can bill for a lower level of care while the patient is still in the hospital.

- prior approval must be obtained by filing an FL-2 form before billing for the lower level of care
- to receive per diem for a lower level of care, the facility must submit a claim showing discharge from the acute level. A **separate** claim must be submitted for the admission to a lower level of care
- if the patient's condition changes to an acute level of care, a claim must be submitted showing discharge from the lower level. A separate claim must be submitted showing the readmission to acute care

See "UB-92 Examples" for additional information.

Lower-Level Ventilator-Dependent Care

Days for lower than acute level of care for ventilator-dependent recipients in swing-bed hospitals or in those that have been downgraded through the utilization review process may be paid up to 180 days at a lower-level ventilator-dependent rate if the hospital is unable to place the patient in a lower-level facility.

Retrospective Review for Lower Level of Care

DMA may make a retrospective review of any transfers to a lower level of care prior to the expiration of the average length of stay for the applicable DRG. DMA may adjust the DRG payment if the transfer is deemed inappropriate, based on a review of the recipient's medical record.

This series of discharge/readmit/discharge claims can be contained in one medical record for Medicaid purposes. Postpayment reviews will verify the medical necessity of the placement level, not whether there is one medical record for each claim.

Appropriate Billings Using Utilization Review Report

When a hospital utilization review (UR) committee performs an inpatient concurrent review and determines acute care is no longer necessary, UR must note that date and indicate whether skilled or intermediate care is appropriate. EDS Prior Approval Unit must be contacted for SNF/ NF prior approval.

The hospital billing office uses the UR notice to correctly bill for approved acute care days only. For those days indicated as skilled or intermediate level of care, the hospital can bill the appropriate level per diem rate. The hospital cannot bill Medicaid for days the recipient is awaiting other discharge arrangements, i.e., home or adult care home.

If a hospital consistently fails to bill Medicaid properly, resulting overpayments will be subject to recoupment.

Outpatient Claims

Billing

1. All claims for outpatient services must be submitted as a Bill Type 131.
   - all related outpatient services, including ambulatory procedures, rendered within 24 hours of an inpatient admission to the same hospital must be included with the inpatient billing
   - if the inpatient claim is paid first, a subsequent outpatient claim will deny
     - an inpatient replacement claim, Bill Type 117, can be resubmitted to reflect the outpatient charges and procedures
   - if the outpatient claim pays first and the inpatient claim comes in later, the outpatient claim is recouped to pay the inpatient claim
     - an inpatient replacement claim, Bill Type 117, may be resubmitted to reflect the outpatient charges
2. Following these steps establishes an audit trail showing that outpatient service charges were correctly carried forward to the inpatient billing filed with Medicaid.
3. Admit and Discharge hours are required fields on the UB-92. Accuracy is vital to assure correct payment of claims.

See "UB-92 Examples" for Bill Type 131 example.

Outpatient Procedures

If an inpatient recipient needs a medically necessary outpatient procedure that cannot be performed at that facility, and the procedure is performed at a different facility, both facilities can be paid for the actual services each one rendered. If that outpatient procedure is performed at the same facility while the recipient is an inpatient, the outpatient procedure will deny; these outpatient charges should be bundled into the inpatient bill. The DRG payment is considered payment in full for all procedures and services rendered during the inpatient stay.

Outpatient Crossover Claims

Billing

EDS receives outpatient crossover claims from the Medicare carrier via tape or on paper from the provider. Paper claims from the provider must have a matching Medicare voucher attached. Medicaid pays only the coinsurance and/or the deductible on outpatient crossovers.

Claims Submission

Physician Attestation

A signed physician attestation prior to submitting a Medicaid claim concerning the principal and secondary diagnoses and the major procedure performed is not required. The responsibility for verification is the hospital's.

Paper Claims

The maximum number of lines allowed is 23.
Submit inpatient claims requiring more lines than allowed as paper claims with "multiple page claim" on front of each envelope.
Abortion statements required for therapeutic abortions must be submitted with a paper claim.

Certification for Signature on File	Paper claims may be filed without an individual signature on each claim if the provider has submitted a "Provider Certification for Signature on File" form. The system annotates to indicate the certification for signature on file during the claim process. See Attachment D at the end of this chapter. Contact EDS Provider Relations for further information. See Appendix B.

Continued on next page

Claims Submission, Continued

Electronic Claims

The maximum number of lines allowed is 28. Sterilization and hysterectomy claims may be filed electronically. Mail the consent or statement on the same date. See Appendix B.

Time Limit

All Medicaid claims except hospital inpatient and nursing facility claims must be received by EDS within 365 days of the date of service in order to receive payment. Hospital inpatient and nursing facility claims must be received within 365 days of the last date of service on the claim.

Time-limit Overrides

DMA and EDS have limited authority under federal regulations to override the billing time limit. The following are examples of acceptable documentation to review for time-limit override:

- correspondence about the specific claim received from DMA and/or EDS
- an explanation of Medicare benefits or other third party benefits dated within 180 days from the date payment or denial
- a copy of the Remittance Advice (RA) showing the claim pending or denied
  - ♦ the denial must be for reasons other than the time limit

Claims with attachments for time-limit overrides must be sent to EDS Provider Services. Submitting a billing date on claims only or a copy of the office ledger is not acceptable documentation. Submission dates do not verify that the claim was received within the 365-day time limit.

Requests for adjustment or reconsideration of a denied claim must be received within 18 months of the date of payment or denial.

Diagnosis and Procedure Coding

Use appropriate ICD-9 diagnosis and procedure codes. All coding must adhere to ICD-9 guidelines and must include the fifth (5th) digit when applicable.

UB-92 Preadmission Instructions

Preadmission review by First Mental Health (FMH) is required for all psychiatric admissions to designated hospitals, whether elective or emergency through age 64. Below is an outline of specific information that needs to be completed on the UB-92:

Special Instructions: For the types of admissions listed below, the hospital must enter the special authorization number of 699999999 in Form Locator 63 ("Treatment Authorization"). This special code will alert claims processing that a preadmission review was not necessary.

- Dentists—The patient is being admitted by a dentist for treatment.
- Medicare Benefits Exhausted —If a patient eligible for both Medicare A and Medicaid enters the hospital as a Medicare patient, but exhausts his benefits during the stay, Medicaid is now the primary payer, and preadmission certification must be obtained or special authorization number 699999999 must be in Form Locator 63.
- Prior Approval—For hospitals not subject to First Mental Health review, the above number must be entered. For these services, the hospital should enter the prior approval (PA) number in Form Locator 63 ("Treatment Authorization"). The claim will be denied if prior approval is not obtained.

Acute Care Admission

The following examples illustrate the correct claims procedures effective for claims with a To Date of Service in 1998.

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Claims Submission, Continued

Admit Through Discharge-Bill Type 111

The preferred method for claims submission is one claim for the recipient's entire stay using a 111 Bill Type, "admit through discharge."

- the DRG-allowable is calculated and DSH amounts and outlier (cost or day) are added to represent the DRG maximum allowable
- patient liability, deductible balance, and third party liabilities are then applied

When submitting a claim for Admit Date through the Discharge Date, the following applies:

- the Admit Date must equal the From Date of Service
- the Patient Status must be discharged, expired, or transferred (01–08 or 20)

Example

Claim Data					
Type of Bill	111	Patient Status	01	Admit Date	1-15-2000
FDOS	1-15-2000	TDOS	2-15-2000		

This claim will pay at the calculated DRG maximum-allowable.

See "UB-92 Examples" for Type of Bill 111.

First Interim Claims–Bill Type 112

First interim claims can only be submitted if the covered days span at least 61 days. All first interim claims submitted with an interim Bill Type that are less than a 61-day span will deny. The first interim claim should be submitted with a 112 Bill Type, indicating Interim–First Claim and a Patient Status of 30 (still a patient). The DRG is assigned to this claim and the DRG-allowable will be paid. This amount may NOT be the final DRG payment. Subsequent claims, interim/final, may affect payment.

Continuing Interim Claims-Bill Type 117

All continuing interim claims received after the initial interim claim are treated as "replacement claims."

When the replacement claim is processed, the RA will reflect a complete recoupment of the previous claim submitted with a 112 or 117 Bill Type. Each time a replacement claim is processed, the previous payment is recouped on the same RA. The new payment amount will include any additional outlier payments or change in DRG.

Submit continuing interim claims only if at least 60 days separate the To Date of Service on the previous claim from the To Date of Service on the current claim.

Claims Processing Cycle Information

Medicaid's objective is to obtain a discharge claim for every hospital stay. Hospitals must submit a discharge claim for each stay to complete the information on that stay. To encourage timely billing and prevent open-ended sets of claims (sets with no discharge), some claims may be recouped.

- if a subsequent claim is not received within 180 days of the pay date on the RA of the previous claim, the previous payment will be recouped
- some claims outside the 180-day guideline may not be recouped on the exact 180th day because the claims processing cycle auditing interim claims runs every 30 days
- recoupments will not occur until a minimum of 180 days has elapsed

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Claims Submission, Continued

Claims Processing Cycle Information, (continued)

Medicaid will pay for stays that have been recouped because the discharge claim was not submitted within 180 days. The provider should resubmit a claim for the entire stay using Bill Type 111 or combinations of Bill Type 112 and Bill Type 117.

The only valid Bill Type for replacement claims is 117. Any inpatient claim with a continuing interim Bill Type of 113 will deny.

The replacement claim methodology is effective for inpatient claims only. Outpatient claims are not reimbursed by DRG, and outpatient claims submitted with a Bill Type 137 will deny.

Discharge Claims–Bill Type 117

The final claim must be submitted with a 117 Bill Type and a Patient Status of discharged, expired, or transferred (01–08 or 20). All inpatient claims with a 114 Bill Type will deny.

- if the discharge claim is not received within 180 days of the pay date on the RA of the previous claim, **ALL** previous payments will be recouped
- some claims outside the 180-day guideline may not be recouped on the exact 180th day because the claims processing cycle auditing interim claims runs every 30 days

Any errors made on a previously paid claim submitted with a Bill Type 111 can be corrected by submitting a replacement claim. This replacement claim must be submitted with a Bill Type 117 and must reflect all diagnoses, procedures, charges, and liability amounts for the entire stay.

Reminders

- all interim claims must have an Admit Date equal to the From Date of Service
- first interim claims can only be billed with a Patient Status of 30 (still a patient)
- all discharge claims must be billed with a Bill Type 117 and a Patient Status of 01–08 or 20
- the only valid Bill Type for first interim claim is 112. The only valid Bill Type for other interim claims is 117
- information submitted on replacement claims must reflect all accumulated charges and dates
- all third party and patient liability amounts must be accumulated amounts for the entire stay
- every claim must reflect the appropriate diagnoses and procedures for the entire stay
- "rolling-up" revenue codes can destroy important information

Examples

The following examples track the claims process for a hospital stay through discharge:

Claim 1					
Type of Bill	112	Patient Status	30	Admit Date	01-01-2000
FDOS	01-01-2000	TDOS	04-05-2000		

This claim will pay at the DRG-allowable plus any applicable outlier payments.

Claim 2					
Type of Bill	117	Patient Status	30	Admit Date	01-01-2000
FDOS	01-01-2000	TDOS	07-03-2000		

This claim replaces the previous claim and pays at the allowable DRG. Payment for Claim 1 is recouped and outliers are paid for Claim 2, if applicable. At least 60 days separate the TDOS for Claim 1 and the TDOS for Claim 2.

Claims Submission, Continued

Claim 3					
Type of Bill	117	Patient Status	01	Admit Date	01-01-2000
FDOS	01-01-2000	TDOS	08-08-2000		

This claim will pay at the DRG maximum-allowable. Payment for Claim 2 is fully recouped, and the claim is replaced and paid by Claim 3. For Claims 2 and 3 in this example, all accumulated charges, third party and patient liabilities, and appropriate diagnoses and procedures entered reflect the entire length of stay.

Lower Level of Care

Claims for lower level portions of a hospital stay are submitted following per diem guidelines. The following examples show a patient whose condition changes from acute care to lower level of care and then back to acute care.

This claim shows the patient as being discharged from acute care to a lower level of care. The DRG maximum-allowable is paid and includes the DRG-allowable and any outlier payments.

Claim 1					
Type of Bill	111	Patient Status	03	Admit Date	01-06-2000
FDOS	01-06-2000	TDOS	05-08-2000		

This claim pays at the state's average per diem rate:

Claim 2					
Type of Bill	182	Patient Status	30	Admit Date	05-08-2000
FDOS	05-08-2000	TDOS	05-31-2000		

This claim shows that the patient is discharged to a nursing facility. This claim pays at per diem rates.

Claim 3a					
Type of Bill	184	Patient Status	03	Admit Date	05-08-2000
FDOS	06-01-2000	TDOS	06-19-2000		

This claim shows that the patient's condition changes to acute care. The patient is readmitted to the hospital (see Claim 4). This claim pays at the state's average per diem rate.

Claim 3b					
Type of Bill	184	Patient Status	02	Admit Date	05-08-2000
FDOS	06-01-2000	TDOS	06-19-2000		

This claim pays DRG as a new admission.

Claim 4					
Type of Bill	111	Patient Status	03	Admit Date	06-19-2000
FDOS	06-19-2000	TDOS	08-04-2000		

UB-92 Claim Form Instructions

Instructions The following UB-92 instructions are for hospital inpatient services, hospital outpatient services, and hospital lower level of care services.

Form Locator/Description	Requirements	Remarks
1. Provider Name/Address	Required	Name and 1–3 lines of address. Please use name as it appears on the Remittance Advice (RA). Do not abbreviate.
3. Patient Control Number	Desired	Patient control number or medical record number that the provider has elected to appear on their RA. This number will be keyed by EDS and reported back to the provider in the medical record field of the RA. This field will hold up to 20 digits alpha or numeric. Only the first 9 digits of this number will appear on the RA.
4. Type of Bill	Required	**Inpatient:** 111 - Admit through discharge claim 112 - First interim claim 117 - Continuing interim claim (Replacement) **Outpatient:** 131 - Outpatient **Lower Level of Care** 17X - Intermediate 18X - Skilled
5. Federal Tax Number	Required, where applicable	
6. Statement Covers Period	Required	The beginning and ending dates of the period covered by this bill. The From Date of Service must match the Admission Date located in Form Locator 17 for hospital inpatient acute care.
7. Covered Days	Required	Indicate number of days to be billed on this claim form.
9. Coinsurance Days	Required for inpatient crossovers	Indicate any coinsurance days used this period.
10. Lifetime Reserve Days	Required where applicable	Indicate any lifetime reserve days used for this period.

Continued on next page

UB-92 Claim Form Instructions, Continued

Instructions for Completing the UB-92 Claim Form (continued)

Form Locator/Description	Requirements	Remarks
11. Carolina ACCESS Number	Required for inpatient crossovers	Carolina ACCESS number from the recipient's Primary Care Physician.
12. Patient Name	Required	Enter patient's name exactly as shown on the MID card; last name, first name, and middle initial. Do not use nicknames.
13. Patient Address	Required	The address of the patient should include a minimum of city and state.
14. Patient Birth Date	Required	Enter MMDDYYYY. Example: January 1, 1997 would be indicated as 01011997.
15. Patient Sex	Required	One alpha position indicating the sex of the patient. Valid characters are "M", "F", or "U."
17. Admission Date	Required	Admission date cannot exceed six positions and should be listed in MM/DD/YY format. Enter on all claims. The date must match the "From" date in Form Locator 6. Date must be the first billable event.
18. Admission Hour	Required	Time / Code / AM / Code / PM 00 12:00-12:59 Midnight 12 12:00-12:59 Noon 01 01:00-01:59 13 01:00-01:59 02 02:00-02:59 14 02:00-02:59 03 03:00-03:59 15 03:00-03:59 04 04:00-04:59 16 04:00-04:59 05 05:00-05:59 17 05:00-05:59 06 06:00-06:59 18 06:00-06:59 07 07:00-07:59 19 07:00-07:59 08 08:00-08:59 20 08:00-08:59 09 09:00-09:59 21 09:00-09:59 10 10:00-10:59 22 10:00-10:59 11 11:00-11:59 23 11:00-11:59 For multiple outpatient visits on the same day indicate admit hour and submit each visit on a separate claim.

Continued on next page

UB-92 Claim Form Instructions, Continued

Instructions for Completing the UB-92 Claim Form (continued)

Form Locator/Description	Requirements	Remarks
19. Admission Type	Required	Indicate applicable code on all inpatient visits. A 1 must also be indicated on emergency room visits that meet emergency criteria to prevent copayment deduction. 1 **Emergency:** The patient requires immediate intervention as a result of severe, life threatening or potentially disabling conditions. Generally, the patient is admitted through the emergency department. 2 **Urgent:** The patient requires immediate attention for the care and treatment of a physical or mental disorder. Generally the patient is admitted to the first available and suitable accommodation. 3 **Elective:** The patient's condition permits adequate time to schedule the availability of a suitable accommodation. 4 **Newborn:** Any newborn infant admitted to the hospital within the first 24 hours of life.
20. Source of Admission	Required	1 **Physician Referral:** Inpatient: The patient was admitted to this facility upon the recommendation of his or her personal physician. Outpatient: The patient was referred to this facility for outpatient or referenced diagnostic services by his or her personal physician or the patient independently requested outpatient services (self-referral). 2 **Clinic Referral:** Inpatient: The patient was admitted to this facility upon recommendation of this facility's clinic physician. Outpatient: The patient was referred to this facility for outpatient or referenced diagnostic services by this facility's clinic or other outpatient department physician.

Continued on next page

UB-92 Claim Form Instructions, Continued

Instructions for Completing the UB-92 Claim Form (continued)

Form Locator/Description	Requirements	Remarks
20. Source of Admission (Continued)	Required	3. **HMO Referral:** Inpatient: The patient was admitted to this facility upon the recommendation of a health maintenance organization physician. Outpatient: The patient was referred to this facility for outpatient or referenced diagnostic services by a health maintenance organization physician. 4 **Transfer From a Hospital:** Inpatient: The patient was admitted to this facility as a transfer from an acute care facility where he or she was an inpatient. Outpatient: The patient was referred to this facility for outpatient or referenced diagnostic services by (a physician of) another acute care facility. 5 **Transfer From a Skilled Nursing Facility:** Inpatient: The patient was admitted to this facility as a transfer from a skilled nursing facility where he or she was an inpatient. Outpatient: The patient was referred to this facility for outpatient or referenced diagnostic services by (a physician of) the skilled nursing facility where he or she is an inpatient. 6 **Transfer From Another Health Care Facility:** Inpatient: The patient was admitted to this facility as a transfer from a health care facility other than an acute care facility or a skilled nursing facility. This includes transfers from nursing homes, long term care facilities and skilled nursing facility patients that are at a nonskilled level of care. Outpatient: The patient was referred to this facility for outpatient or referenced diagnostic services by (a physician of) another health care facility where he or she is an inpatient.

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UB-92 Claim Form Instructions, Continued

Instructions for Completing the UB-92 Claim Form (continued)

Form Locator/Description	Requirements	Remarks
20. Source of Admission (Continued)	Required	7 **Emergency Room:** Inpatient: The patient was admitted to this facility upon the recommendation of this facility's emergency room physician. Outpatient: The patient was referred to this facility for outpatient or referenced diagnostic services by this facility's emergency room physician. 8 **Court/Law Enforcement:** Inpatient: The patient was admitted to this facility upon the direction of a court of law, or upon the request of a law enforcement agency representative. Outpatient: The patient was referred to this facility upon the direction of a court of law, or upon the request of a law enforcement agency representative for outpatient or referenced diagnostic services. 9 **Information Not Available:** Inpatient: The means by which the patient was admitted to this hospital is not known. Outpatient: For Medicare outpatient bills this is not a valid code. A-Z **Reserved for National Assignment.**

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UB-92 Claim Form Instructions, Continued

Instructions for Completing the UB-92 Claim Form (continued)

Form Locator/Description	Requirements	Remarks
20. Source of Admission (Continued)		**For Newborns:** 1 **Normal Delivery:** A baby delivered without complications. 2 **Premature Delivery:** A baby delivered with time and/or weight factors qualifying it for premature status. 3 **Sick Baby:** A baby delivered with medical complications, other than those relating to premature status. 4 **Extramural Birth:** A newborn born in a non-sterile environment. 5-8 **Reserved For National Assignment.** 9 **Information Not Available**
21. Discharge Hour	Required	Time / Time Code AM / Code PM 00 12:00-12:59 Midnight / 12 12:00-12:59 Noon 01 01:00-01:59 / 13 01:00-01:59 02 02:00-02:59 / 14 02:00-02:59 03 03:00-03:59 / 15 03:00-03:59 04 04:00-04:59 / 16 04:00-04:59 05 05:00-05:59 / 17 05:00-05:59 06 06:00-06:59 / 18 06:00-06:59 07 07:00-07:59 / 19 07:00-07:59 08 08:00-08:59 / 20 08:00-08:59 09 09:00-09:59 / 21 09:00-09:59 10 10:00-10:59 / 22 10:00-10:59 11 11:00-11:59 / 23 11:00-11:59

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UB-92 Claim Form Instructions, Continued

Instructions for Completing the UB-92 Claim Form (continued)

Form Locator/Description	Requirements	Remarks
22. Patient Status	Required	01 Discharged to home or self care (routine discharge). 02 Discharged/transferred to another short-term general hospital 03 Discharged/transferred to skilled nursing facility (SNF). 04 Discharged/transferred to an intermediate care facility (ICF). 05 Discharged/transferred to another type of institution for inpatient care or referred for outpatient services to another institution. 06 Discharged/transferred to home under care of organized home health service organization. 07 Left against medical advice. 08 Discharged/transferred to home under care of a home IV provider. 20 Expired 30 Still patient or expected to return for outpatient services.
23. Medical Record Number	Desired	Can be alpha or numeric. For provider use only
24–30. Condition Codes	Required where applicable	46 If the patient is covered by CHAMPUS, use this code if you have a nonavailability statement on file 87 **Medicare Part A Noncovered service or does not meet Medicare criteria for Part A:** The use of this code will override the Medicare Part A indicator on file. 89 **Medicare Part B Noncovered service or does not meet Medicare criteria for Part B:** The use of this code will override the Medicare Part B indicator on file.

Continued on next page

UB-92 Claim Form Instructions, Continued

Instructions for Completing the UB-92 Claim Form (continued)

Form Locator/Description	Requirements	Remarks
32–35. a–b Occurrence Codes and Dates	Required where applicable	**Accident-Related Codes** 24 **Date Insurance Denied:** The use of this code and corresponding date will allow the provider to file the claim with Medicaid without an attachment. The TPL indicator will be overridden. 25 **Date Benefits Terminated By Primary Payer:** The use of this code and corresponding date is self explanatory and will, also, cause the TPL indicator to be overridden. **Special Codes** A3 **Benefits Exhausted:** Code indicating the last date for which benefits are available and after which no payment can be made by payer A. B3 **Benefits Exhausted:** Code indicating the last date for which benefits are available and after which no payment can be made by payer B. C3 **Benefits Exhausted:** Code indicating the last date for which benefits are available and after which no payment can be made by payer C.
39–41. a–d Value Codes and Amounts	Required where applicable	Enter any value code pertinent to this claim. Applicable deductible/patient liability amounts should be indicated in this Form Locator block with a value code of 23. 23 **Recurring Monthly Income:** Medicaid eligibility requirements to be determined at state level. ***Include code 23 and value (even if it is 0) for any hospital inpatient stay extending beyond the first of the month following the 30th consecutive day of admission.**
42. Revenue Code	Required	Refer to program specific Medicaid manual for applicable codes. (Hospitals should also refer to UB-92 manual).
43. Revenue Code Description	Not required	

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UB-92 Claim Form Instructions, Continued

Instructions for Completing the UB-92 Claim Form (continued)

Form Locator/Description	Requirements	Remarks
44. HCPCS/Rates	Required where applicable	When billing RCC 300–310 enter applicable HCPCS code for hospital outpatient labs.
45. Service Date	Required where applicable	Indicate individual service date for each line item billed. * Required if multiple dates of service are billed on one outpatient claim. * NECS Software - Require date for single date of service
46. Unit of Service	Required where applicable	Enter number of units for each detail line. Refer to program specific manual for definition of unit.
47. Total Charges	Required	The total of the amounts in this column are added and recognized by the Revenue Code 001.
48. Noncovered Charges	Required where applicable	Amounts indicated in this block will be deducted from allowable payment.
50. a, b, c **Payer A, B, C**	Required	Enter Payer Classification Code and Specific Carrier Identification Codes of each of up to three payers listed in order of priority. Payer information entered on lines a, b, or c should correspond with any information indicated in form locators 37, 52–66. A Primary payer B Secondary payer C Tertiary payer **Payer Classification Codes** Medicare M Medicaid D Blue Cross B Commercial Insurance I CHAMPUS C NC DEHNR-Purchase of Care N Worker's Compensation W State Employee Health Plan E Administered Plans S Health Maintenance Organization H Self-Pay/Indigent/Charity P Other O

Continued on next page

UB-92 Claim Form Instructions, Continued

Instructions for Completing the UB-92 Claim Form (continued)

Form Locator/Description	Requirements	Remarks
50. a, b, c **Payer A, B, C** (Continued**)**	Required	**Specific Carrier Identification Codes** Payer Classification — Carrier Code — Explanatory Notes Medicare (M) — 0000 — 4 zeros Medicaid (D) — NC00 — Where NC = postal state code Blue Cross (B) — 0XXX — Where XXX = Blue Cross Plan Code or FEP Commercial Insurer (I) — XXXX — Where XXXX = Docket Number Commercial Insurer (I) — 9999 — When docket number is unassigned CHAMPUS (C) — 0000 — 4 zeros NCDEHNR-Purchase of Care — 0000 — 4 zeros Worker's Compensation — XXXX — Where XXXX = Docket Number Worker's Compensation — 9999 — When docket number is unassigned State Employees Hlt Plan — 0000 — 4 zeros Administered Plan (S) — 0000 — 4 zeros Health Maintenance Organization (H) — XXXX — Where XXXX = Docket Number Health Maintenance Organization (H) — 9999 — When docket number is unassigned Self-Pay/Indigent/Charity (P) — 6666 — Self pay-hospital bills patient and expects payment
51. a, b, c **Provider Number**	Required	Number assigned to provider by Medicaid as shown on the RA. Do not use extra zeros or dashes.

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UB-92 Claim Form Instructions, Continued

Instructions for Completing the UB-92 Claim Form (continued)

Form Locator/Description	Requirements	Remarks
54. a, b, c Prior Payments–Payers	Required where applicable	Any applicable commercial insurance amount should be indicated. Medicare Part B payment amount should be entered in this block for hospital inpatient claims when Part A benefits are exhausted or not applicable to this claim. Amounts entered in this block will be deducted from allowable payment.
60. a, b, c Certificate/Social Security/ Health Insurance Claim/ Identification Number	Required	Enter 10-digit Medicaid ID number as indicated on recipient's MID card.
63. a, b, c Treatment Authorization Code	Required where applicable	Enter applicable 9-digit prior approval number for inpatient hospital Lower Level of Care claims or the psychiatric PA number from First Mental Health.
67. Principal Diagnosis Code	Required	Enter applicable ICD-9-CM diagnosis code.
68–75. Other Diagnosis Codes	Required where applicable	Enter any additional diagnosis codes.
76. Admitting Diagnosis	Required, Inpatient only	Enter ICD-9 code for admitting diagnosis.
80. Principal Procedure Code and Date	Required	Enter any surgical or diagnostic procedures performed during this period. Use only ICD-9-CM procedure codes.
81. a-e Other Procedure Codes and Dates	Required	Enter any additional surgical or diagnostic procedures during this period.
84. Remarks	Required where applicable	Enter any information applicable to specific claim billed.
85. Provider Representative Signature	Required	**Note:** This field is not required if the provider number has been updated with a Certification for Signature on File.
86. Date Bill Submitted	Desired	Enter date the claim was submitted.

UB-92 Claim Form Examples

Bill Types

The following UB-92s are examples of (1) Bill Type 111 (admit through discharge), (2) Bill Type 131 (outpatient services), (3) Bill Type 171 (lower level of care-intermediate care), and (4) Bill Type 181 (swing-bed lower level of care–skilled).

Continued on next page

Attachment D

NORTH CAROLINA DIVISION OF MEDICAL ASSISTANCE

PROVIDER CERTIFICATION
FOR
SIGNATURE ON FILE

By signature below, I understand and agree that non-electronic Medicaid claims may be submitted without signature and this certification is binding upon me for my actions as a Medicaid provider, my employees, or agents who provide services to Medicaid recipients under my direction or who file claims under my provider name and identification number.

I certify that all claims made for Medicaid payment shall be true, accurate, and complete and that services billed to the Medicaid Program shall be personally furnished by me, my employees, or persons with whom I have contracted to render services, under my personal direction.

I understand that payment of claims will be from federal, state and local tax funds and any false claims, statements, or documents or concealment of a material fact may be prosecuted under applicable Federal and State laws and I may be fined or imprisoned as provided by law.

I have read and agree to abide by all provisions within the NC Medicaid provider participation agreement and/or on the back of the claim form.

SIGNATURE:

_____

Print or Type Business Name of Provider

_____

Signature of Provider Date

Group provider number to which this certification applies: _____

Attending provider number to which this certification applies: _____

Return completed form to:

EDS
Provider Enrollment
P.O. Box 300009
Raleigh, NC 27622

Attachment E

If providers have Medicare claims that are not automatically crossing over to Medicaid, they should complete the form below and return to EDS PROVIDER ENROLLMENT. DO NOT SEND THIS FORM TO MEDICARE. Provider Enrollment will verify the provider's Medicare and Medicaid information. If the numbers are not cross-referenced, EDS will add the provider information to the crossover file. If Provider Enrollment has any questions, they will contact the provider.

If you have multiple Medicare carriers and Medicare provider numbers, each number must be referenced to a Medicaid provider number. Please use a separate form for each cross-reference.

Note: Multiple Medicare numbers can be cross-referenced to a single Medicaid number, but multiple Medicaid numbers **cannot** be cross-referenced from a single Medicare number.

Prompt return of this information will help ensure crossover claims are processed correctly and in a timely manner. Fax forms to 919-851-4014, ATTN: Provider Enrollment or mail to the address listed at the bottom of the form.

MEDICARE CROSSOVER REFERENCE REQUEST

Provider Name: _____

Contact Person:(required) _____ Telephone Number: (required) _____

Indicate your *Medicare Carrier,* the *Action to be taken,* and your *Medicare* and *Medicaid* provider numbers**. If this section is not completed, the form will not be processed.**

These are the only carriers for which EDS can currently cross-reference provider numbers.

- ☐ NC BC/BS
- ☐ TN BC/BS
- ☐ FL BC/BS *****
- ☐ TX BC/BS
- ☐ MS BC/BS
- ☐ Palmetto
- ☐ Riverbend Government Benefits Administration
- ☐ Mutual of Omaha *****
- ☐ United Healthcare *****
- ☐ CIGNA
- ☐ United Government Services of WI
- ☐ Adminq Star*****
- ☐ GA BC/BS
- ☐ Other_____

Action to be taken:

☐ *Addition - This is used to add a new provider number (Medicare or Medicaid) to the crossover file.*

Medicare Provider number: _____ Medicaid Provider number: _____

☐ *Change - This is used to change an existing provider number (Medicare or Medicaid) on the crossover file.*

Medicare Provider number: _____ Medicaid Provider number: _____

Mail to: Provider Enrollment
EDS
PO Box 300009
Raleigh, NC 27622

***** These are additional Medicare carriers whom EDS is in the process of working with to have claims cross over with North Carolina Medicaid.